UNCOMPENSATED CARE POOL

REGULATION IMPLEMENTATION
Q's & A's Vol. 2

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TABLE OF CONTENTS

Application Questions:

If a provider is not on the Virtual Gateway as of 10/1/04, does every applicant for UCP have to fill out an MBR?

No, providers are not required to generate an MBR for applicants if the provider is not on the Virtual Gateway and is using the old Free Care electronic software. As of 10/1/04 the MBR can be used as an application for both UCP and MassHealth. Using the MBR will allow patient data to be processed through the MA-21 system that links to REVS. This will allow an applicant's determination to be state-wide and visible on REVS.

Which eligibility determination is valid if a patient receives a determination letter from MassHealth that has a different determination than is done at a provider location?

Once a determination has been made through the MA-21 system and visible on REVS, that determination is the valid determination—even if the provider is not on the Virtual Gateway and has the ability to use the old Free Care software determination system to do a determination that has a different result. If that patient has been determined through MA-21 at a different provider location or through a MassHealth automatic re-determination process, *the determination made through MA-21 is the valid determination.* All providers should check REVS first for any patient determination information.

What is the policy on deductibles if there are differing deductible determinations?

During this transition period, the Division will allow some provider discretion in the matter of partial free care deductibles. If a provider has a UCP eligible patient with a deductible and then REVS indicates a different deductible amount, the provider may choose to apply the lower deductible.

For example, if a patient's deductible from the hospital's FC determination is the lower of the two, the hospital can use that one until the patient's one year of eligibility expires. The opposite situation may also occur, in which the deductible calculated at the hospital is actually higher than the one that shows up on REVS. In that case, again, the hospital has a choice of which deductible it wants to use - the lower one on REVS or the higher one in its own FC database.

This discretion applies solely to deductibles; determinations of eligibility types and categories that are visible on REVS are the valid determinations. The UCP is always the payer of last resort and if REVS indicates MassHealth eligibility, a provider must bill MassHealth first, with the Pool billed for any uncovered UCP eligible services.

Has the policy for one-time UCP eligibility for charges <$500 changed?

As of 10/1/04, there is no longer any one-time UCP eligibility for charges <$500. This provision has been eliminated from the UCP regulations.

Are there condensed applications?

Yes, condensed applications can still be used while providers are using the old electronic Free Care application system.

During the transition period can providers use the summary pages from the Common Intake Application along with a Condensed Free Care Application to submit a free care application?

Yes, providers can use the summary pages from the Virtual Gateway common intake application along with a Condensed Free Care Application to submit a free care application. The summary pages from the Common Intake Application serve as an alternate MBR or full free care application, and meet the requirements for information needed for a Condensed FC Application.

What if a patient has submitted a Virtual Gateway application but is waiting for a determination, and presents for services at a different provider?

This patient's status is pending. S/he should not submit another application. The provider can contact the original provider where the application was completed to inquire about its status. The provider also can contact the MEC at 1-888-665-9993 to check the status of an application.

How is residency verified for homeless people?

The MBR and Virtual Gateway common intake forms include an indicator for homelessness that enables complete processing of the application and prevents homeless MassHealth members or UCP users from being disenrolled due to a lack of residence.

Has the verification process for residency changed?

Beginning 10/1/04, residency verification for the UCP will be done through MA-21 for all UCP applications made using the Virtual Gateway or paper MBR. Low Income Patients must be Massachusetts residents, but, in accordance with the MassHealth application process, residency will be established through letters to applicants sent by MA-21. If a letter is returned for an inaccurate address, it will be assumed the applicant is a non-resident and MA-21 will automatically disenroll the person off of Uncompensated Care.

For facilities that continue to use the electronic Free Care application, the current documentation procedures remain the same and patients must supply the required residency and income documentation.

Will MA-21 accept patient affidavits of income and residency as "reliable evidence" and if not, how do we verify that a person is not working?

As of 10/1/04, UCP eligibility determinations through MA-21 will be completed according to the MassHealth rules of necessary documentation.

For applicants with income, MassHealth documentation is required for all eligibility determinations. For income documentation, MassHealth considers affidavits "reliable evidence" only as a last resort when no other documentation is available. If an applicant claims no income, then the application will be processed as it is currently for MassHealth applicants with no income; under MassHealth rules, if an applicant has no income, no documentation is required.

Beginning 10/1/04, residency verification for the UCP will be done through MA-21 for all UCP applications made using the Virtual Gateway or paper MBR. Low income patients must be Massachusetts residents. In accordance with the MassHealth application process, residency will be established through letters to applicants sent by MA-21. If a letter is returned for an inaccurate address, MA-21 ends that individual's eligibility for any MassHealth program or UCP.

Facilities that continue to use the electronic free care application after 10/1/04 (before they transition to the Virtual Gateway) must collect Massachusetts residency documentation from UCP applicants, as they do currently.

How do Medicare patients under age 65 apply for UCP?

For these Medicare patients applying for UCP, the electronic free care application should be used.

Will adolescents still be able to receive confidential services?

Minors receiving confidential services under M.G.L. c. 112, Sec. 12F may apply to be determined a Low Income Patient using their own income information and a provider may submit claims for these confidential medically necessary services provided when no other funding is available. An applicant that is a victim of domestic violence or abuse may request that the provider use a different address for correspondence. HCFP will provide training to intake workers to use an alternate address in the address field, as is currently done under MassHealth procedures.

Billing Questions:

Does the new 6 month retroactive billing period apply to all applications after 10/1/04 regardless of whether the provider is using the old or new application process?

Yes, all eligible services for patients applying on or after 10/1/04 are subject to the new 6 month retroactive billing period regardless of which application tool the provider is using.

Has the billing period changed?

Prior policy allowed hospitals to bill within one year of the date of service or application date, whichever is later. The current regulation allows providers to bill to the pool services which were provided for up to 6 months prior to the date of application. Services billed to the Pool after the end of the patient's eligibility period due to billing cycle delays are allowable as long as the service date falls within the patient's eligibility period.

Are MassHealth members still eligible for UCP as wrap-around coverage to pay for co-pays, deductibles, and non-covered services?

As of 10/1/04, wrap-around coverage is as follows:

- MassHealth co-pays with dates of service on or after 10/1/04 are no longer eligible to be billed to the UCP
- MassHealth deductibles with dates of service on or after 10/1/04 are no longer eligible to be billed to the UCP
- Services not covered by MassHealth, but that are UCP "eligible services," are eligible to be billed to the UCP

Can the hospital submit an addendum to their credit and collection policy rather than write a whole new one?

Yes, as long as the addendum is in compliance with the new regulation. Providers have 90 days to submit their credit and collection policies to the Division.

Does the new retroactivity policy apply to Emergency Room Bad Debt claims as well?

No, the retroactivity policy covers only claims for people who have applied for UCP on or after 10/1/04. It does not cover ERBD claims at all. ERBD claims have no time limitation on them; however, providers must show continuous collection activity for all ERBD claims.

Does the new residency requirement apply to ERBD claims as well?

No. Massachusetts residency is required for individuals applying for UCP on or after 10/1/04. Massachusetts residency is not required for claims that are appropriately determined to be ERBD.

Providers are required to check REVS prior to writing off ERBD claims to the Pool in order to ensure that the patient does not have MassHealth or UCP. The requirement is designed to prevent ERBD claims that could be covered by another payer. While out-of-state residents will not show up in REVS, the regulations still require a REVS check.

Will new free care policy allow providers to bill the pool for services provided to MassHealth enrollees who are not covered by MassHealth for failure to pay premiums?

If the patient is processed and determined ineligible for MassHealth because they have failed to pay their MassHealth premium the patient will automatically be screened for determination as a Low Income Patient. If determined to be a Low Income Patient, REVS will indicate their status as a full Free Care or Partial Free Care patient..

For patients on premium assistance, where they have a primary private insurance payer, how will REVS indicate their status?

There are many different types of MassHealth premium assistance coverage types. Different coverage types will have different REVS messages.

Some premium assistance types will have no message on REVS- this is the case when the patient *only* has private insurance for which MassHealth subsidizes the premium. These patients do not have any MassHealth benefits, therefore they do not show up on REVS.

Other members with premium assistance also have Standard coverage. These patients will show up on REVS with the Standard coverage type.

The UCP is always the payer of last resort. Accordingly, if a patient has premium assistance and also has MassHealth benefits, the UCP only provides wrap coverage for those UCP eligible services which MassHealth does not cover.

Can providers bill patients for non-covered services that are now ineligible for UCP due to Critical Access restrictions?

For patients that are eligible for UCP, the regulations clearly stipulate that providers are prohibited from collecting payments from Low Income patients (114.6 CMR 12.08 (3)). Non-UCP-covered services that are still provided to these patients cannot be billed to patients.

Eligibility Questions:

Has the eligibility period changed?

Yes. Under the new Regulations, the eligibility period runs from 6 months prior to the date of application to one year after the date of application.

When will a "low income" determination be considered a state-wide determination?

All eligibility determinations completed through MA-21 after 10/1/04 will be considered state-wide determinations and will not be facility-specific. UCP and MassHealth determinations will be accessible through REVS and eligible providers throughout the state will be able to verify eligibility through REVS.

REVS will always show the richest aid category for an individual. If a patient is eligible for MassHealth then a MassHealth message will be visible; if the patient is only eligible for UCP, then a UCP message will be visible. Once a patient is determined eligible for MassHealth, providers can bill the Pool for wrap-around coverage of eligible services without any additional determinations or applications.

UCP determinations through the "old" free care application process will continue to be facility-specific. These UCP determinations will not be accessible through REVS.

For patients with MassHealth, determined prior to 10/1/04, how does the hospital document their eligibility for UCP wrap-around coverage?

For wrap-around coverage of MassHealth, the provider can keep a REVS print-out documenting MassHealth eligibility. No condensed application is necessary.

If a patient is determined eligible for UCP at a provider using the VG, is that patient's eligibility transferable to other providers? If so, how do they show proof that they are eligible?

Yes, UCP eligibility will be portable if it is determined through the Virtual Gateway or the paper MBR. Any provider, even if they are not yet connected to the Virtual Gateway, can go into REVS and check eligibility.

Are CommonHealth members with income over 400% FPL still eligible for UCP as wrap-around coverage?

Yes, patients who qualify for MassHealth are automatically designated Uncompensated Care eligible. Yes, a patient on CommonHealth with income over 400% FPL is still eligible for UC wrap-around even though they are not under 400% FPL.

Can providers bill the UCP for non-residents?

As of 10/1/04, non-residents cannot be determined eligible for the UCP. However, non-residents with current UCP eligibility (determined prior to 10/1/04) are eligible for reimbursement of services during their eligibility period, only at the facility where they applied. They are not eligible for services at another facility, since their UCP eligibility was facility-specific.

Applications for UCP eligibility for non-residents must be completed and signed by the applicant prior to 10/1/04. These applications may be submitted after 10/1/04 when the delay was a result of providers' inability to process all applications before 10/1/04. Applications completed and signed by non-residents after 10/1/04 will *not* be accepted. Documentation of the application must be kept on-site and is subject to audit.

Non-residents may have bills that are appropriately determined to be ERBD and written off to the Pool.

Are students who are also residents of Massachusetts eligible for wrap-around coverage of all eligible services by the Uncompensated Care Pool?

Yes.

For UCP reimbursement for individuals during their DDU pending period, should these bills be written off to the Pool or should the provider wait to see if the person is really MassHealth eligible?

For UCP eligible claims during a DDU pending period, providers have two options. Eligible claims may be written off to the Pool and later voided if MassHealth approves the disability. Alternatively, the provider may wait until MassHealth eligibility is determined before billing the claims to MassHealth, or billing the UCP if the patient's disability is denied.

The UCP is always the payer of last resort, if the patient is later found to be eligible for MassHealth; the provider is required to void out any claims to the Pool and correctly bill those claims to MassHealth.

Eligible Services:

Are visits (on a hospital campus) solely to obtain ancillary services (radiology, laboratory) allowable under the definition of critical access services?

Yes, these are "eligible services" and therefore may be billed to the Pool.

Are visits to a primary care practitioner (on a hospital campus) to discuss results of diagnostic testing or to follow up on the provision of other ancillary services "eligible services?"

No, these would not be considered "eligible services" for dates of service on or after 10/1/04. However, follow-up visits with a specialist would be considered "eligible services."

What services qualify as eligible medical expenses for a Medical Hardship application?

The regulation stipulates that eligible medical bills for Medical Hardships are "Allowable Medical Expenses." These expenses are not limited to "eligible services," and may include bills for physician visits, tests, surgeries, etc. that are not necessarily eligible for UCP reimbursement.

For Medical Hardship patients, are services eligible for payment limited to critical access, "Eligible Services?"

Yes. Once individuals are approved for Medical Hardship UCP, their eligible services are limited by the critical access restrictions.

If a patient has MassHealth but does not have dental coverage, can providers bill the UCP for these services?

Yes, providers may bill the UCP for wrap-around coverage for medically necessary dental services performed on a patient who has MassHealth as long as the dental services were provided at an acute hospital or CHC that participates in the UCP.

Is outpatient psychiatric treatment a critical access service?
Psychiatric treatment can be considered a critical access service if it requires the use of a specialist, which therefore precludes it from being a primary care service. In this instance, it is an "eligible service."

Can a hospital bill the UCP for EMTALA level screening that took place in a hospital ER even if the screening determines that the patient does not need emergency level services ?
Yes, provided that the patient has been determined to be a low-income patient the emergency level screening is medically necessary and is an "eligible service", which may be billed to the UCP. If the patient is not determined to be a low-income patient, providers must follow the appropriate ERBD collection requirements prior to submitting the claim for screening to the UCP.